

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031558

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 16 Primary Registration District No. 5594 Registrar's No. 116

FILED SEP 12 1962

1. PLACE OF DEATH a. COUNTY Jefferson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cedar Hill			Length of stay in lb		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 31 Lakeside Dr., Lake Adele			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5706 Finkman Av.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RALPH Middle P. Last ALBRIGHT				4. DATE OF DEATH Month September Day 3 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1910	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner			10b. KIND OF BUSINESS OR INDUSTRY Park Heating and Cooling Co.		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Frank Albright			13b. MOTHER'S MAIDEN NAME Stella Gorska			14. NAME OF HUSBAND OR WIFE Eleonore H. Albright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Eleonore H. Albright, 5706 Finkman Av.		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary thrombosis acute Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic Cornary artery disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT-WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 1954 to 9/3/62 and last saw her alive on 9/2/62 Death occurred at 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Robert E. Bauer (Degree of physician)				22b. ADDRESS 3915 Watson		22c. DATE SIGNED 9/2/62 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/7/1962	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri		
24. FUNERAL DIRECTOR Gebken-Benz Mortuary, 2842 Meramec St.				25. DATE RECD. BY LOCAL REG. 9-7-62		26. REGISTRAR'S SIGNATURE Robert E. Bauer	
St. Louis, 18 Mo.							

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 18 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Yau M. Sienore

Licensed Embalmer No.

4343

P. O. Address

St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.